Report to the Legislature

Chemical Dependency Disposition Alternative

Chapter 338, Laws of 1997, Section 27
RCW 13.40.165 and 70.96A.520

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Final Evaluation Report
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EXECUTIVE SUMMARY

The Chemical Dependency Disposition Alternative (CDDA) became effective July 1, 1998, (RCW 13.40.165). This disposition alternative provides local juvenile courts with a sentencing option for chemically dependent youth, allowing judges to order youth into substance abuse treatment instead of confinement. RCW 70.96A.520 requires that:

> *"The department shall prioritize expenditures for treatment provided under RCW 13.40.165. The department shall provide funds for inpatient and outpatient treatment providers that are the most successful, using the standards developed by the University of Washington under section 27, Chapter 338, Laws of 1997." In addition, section 28, Chapter 338, Laws of 1997 requires that " the department shall, not later than January 1 of each year, provide a report to the Governor and the Legislature on the success rates of programs funded under this section."*

To comply with this legislation, an outcome evaluation was conducted to support the annual reports to the Governor and Legislature. This final report describes the results from the 18-month evaluation of the CDDA program.

The CDDA outcome evaluation compares recidivism, substance abuse, and other measures of success between CDDA-sanctioned treatment and standard probation services. Outcomes for youth in Drug Court are compared to similar youth on standard probation services. Outcomes are compared at 18 months from the date CDDA eligibility is determined. Recruitment for the CDDA outcome evaluation occurred between January 1999 and June 2001. A total of 403 youth from 8 counties were recruited into the outcome evaluation. Of these youth, 165 were in CDDA, 53 were in a Drug Court, and 185 were in neither CDDA nor Drug Court.

CDDA had the greatest impact on committable youth. Results revealed that over the 18-month study period, compared to youth receiving standard services, committable youth completing CDDA:

- incurred fewer convictions,
- were less likely to be detained, and if detained spent the least amount of time detained
- were more likely to be enrolled in school
- were more likely to be working full-time
- reported better family and social relationships
- reported fewer emotional difficulties

Locally sanctioned youth completing CDDA also incurred significantly fewer convictions, were less likely to be detained, and if detained spent less time detained. However, significant differences between youth completing CDDA and those not in CDDA were not evident in other areas of functioning, as was the case for committable youth.

Despite the fact that youth in CDDA received significantly more substance abuse treatment services than youth receiving standard services, they did not receive the treatment services prescribed for CDDA youth. Specifically, youth did not receive the expected degree of family services, case management, individual counseling, and urine drug screens. This lack of services may, in part, explain why no significant differences in substance use over time were found between committable and locally sanctioned youth completing CDDA and those on standard services.

To enhance the impact and effectiveness of CDDA, it is recommended* that:

1. Substance abuse treatment providers be required to adhere to the protocol for CDDA treatment services.

2. A method to monitor treatment providers' adherence to CDDA guidelines for treatment services be established.

3. Additional fiscal resources be provided to the CDDA program to ensure that youth in CDDA receive needed family therapy services.

4. The CDDA Advisory Committee is re-convened to address the above issues. The Committee should include at a minimum key stakeholders from JRA, local juvenile courts, the Department of Social and Health Services' Division of Alcohol and Substance Abuse, experts on family treatments, and local treatment providers.

5. Additional study of committable youth in CDDA with a longer follow-up period be implemented.

Although outcomes for youth in Drug Court were assessed in this study, results for Drug Court should be viewed only as preliminary findings. Since youth in Drug Court differed in important ways initially from youth in CDDA, the outcomes of youth in Drug Court should not be compared to those of youth in CDDA. Youth in Drug Court had the least extensive criminal histories compared to locally sanctioned youth in CDDA. Youth completing Drug Court evidenced fewer re-convictions, incarcerations, and less time detained than youth not in Drug Court over the study period. Youth completing Drug Court did not evidence significantly better functioning in other areas compared to youth not in Drug Court. Drug Court participants were generally recruited during the programs' first year of implementation. Significant changes to Drug Court may have been made after review of the program's first year of implementation. Therefore, these findings may not be reflective of current Drug Court services and outcomes for current Drug Court participants.

**Please see the Juvenile Rehabilitation Administration's response to the University of Washington's recommendations in Attachment 1, page 31.*

Introduction

The Chemical Dependency Disposition Alternative (Chapter 338, the Laws of 1997, RCW 13.40.165) became effective July 1, 1998, and provided local juvenile courts with a sentencing option for chemically dependent youth, allowing judges to order youth into treatment instead of confinement. The Department of Social and Health Services' Juvenile Rehabilitation Administration (JRA), in collaboration with the department's Division of Alcohol and Substance Abuse (DASA), was given the responsibility of designing and implementing the Chemical Dependency Disposition Alternative (CDDA).

This legislation also required the University of Washington (UW) to develop standards for measuring the treatment effectiveness of CDDA. These standards were developed by the Alcohol and Drug Abuse Institute (ADAI) of the UW and presented in the 1997 report entitled ***Effectiveness Standards for the Treatment of Chemical Dependency in Juvenile Offenders: A Review of The Literature*** submitted to the Legislature on January 1, 1998. These effectiveness standards are used to determine the efficacy of the CDDA program on an annual basis as required by RCW 70.96A.520.

CDDA represents a collaboration of JRA's, local juvenile courts', and DASA's interests in using community-based programs as an alternative to detention as well as the Legislature's interest in providing sentencing alternatives for chemically dependent and substance abusing juveniles. CDDA also represents a union of juvenile court-administered services and county-coordinated drug and alcohol treatment systems. CDDA provides local communities with a monetary incentive to implement interventions for juvenile offenders that research demonstrates to be effective in reducing substance use among chemically dependent youth. In providing chemically dependent juvenile offenders with effective treatments, substance use should decrease, as should involvement in criminal behaviors. CDDA should not only reduce the state's costs of incarceration for juveniles, but also provide a cost-effective means of improving the overall functioning of juvenile offenders while keeping them in the local community.

This final report focuses on information gathered from the 18-month assessments in the CDDA outcome evaluation. Descriptions of each county's CDDA program and unique features of these programs are provided in Appendix A.

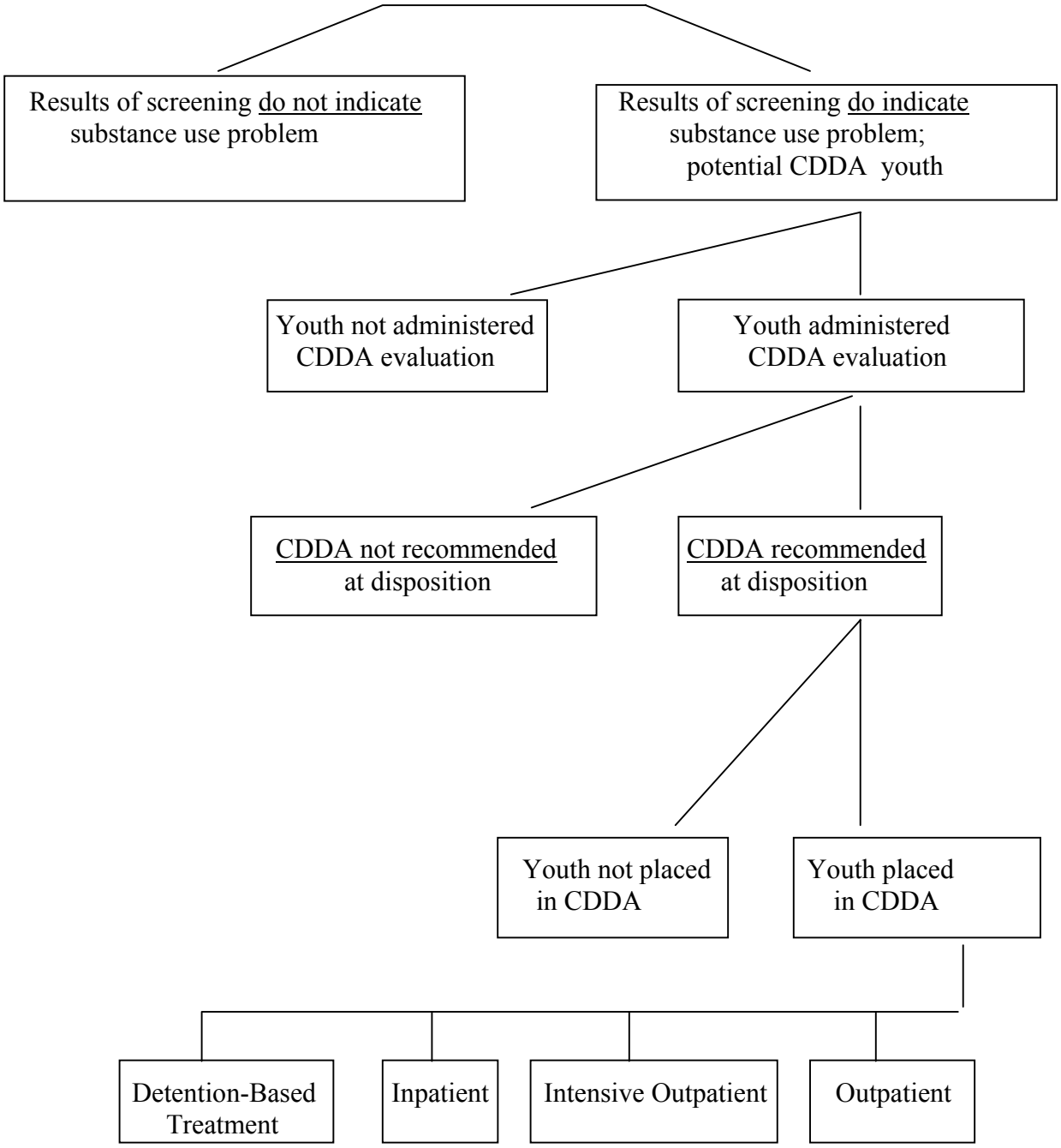
Implementation of CDDA to Date

CDDA became available to all juveniles committing crimes after July 1, 1998. Figure 1 on page 7 presents the steps that occur in determining whether a youth will be placed in CDDA or not. To be eligible for the CDDA program, a youth must:

- be between 13 and 17 years of age,
- have no current A- or B+ charges,
- be chemically dependent or a substance abuser, and
- not pose a threat to community safety.

Figure 1

Juvenile Court Procedures for Determining CDDA Eligibility



Currently, all 33 juvenile courts in Washington have implemented CDDA programs. Nine counties access Title 19 matching funds to increase fiscal resources for their CDDA programs.

CDDA Evaluation Overview

The outcome evaluation was conducted in eight counties. Counties were chosen based on their size, how inclusive the county's CDDA model was of the elements of effective treatment included in the ***1997 Effectiveness Standards*** report and by geographic location. The eight counties involved in the CDDA outcome evaluation are:

Benton/Franklin	Kitsap	Spokane
Clark	Pierce	Yakima
King	Snohomish	

The CDDA outcome evaluation was designed to compare results of assessments of substance use, criminal activity, and functioning in several important domains of life (e.g., family, social, and school). Comparisons were made on these factors between youth receiving CDDA services and other youth that were eligible for CDDA, but did not participate in CDDA. These comparisons were made at baseline (which is when youth were assessed to determine clinical eligibility for CDDA), and again at 6, 12, and 18 months from the date of the initial assessment. Youth from the CDDA and comparison group were followed for an 18-month study period without regard to their CDDA status.

The effectiveness standards that were used to measure outcomes of the groups are:

- Reduced criminal recidivism as evidenced by:
  - reduced criminal convictions
  - reduced incarceration

- Reduced substance use as evidenced by a reduction in:
  - the total number of days of substance use
  - the number of re-admissions to a chemical dependency treatment program (e.g., detox, inpatient, or outpatient)
  - the number of emergency room visits or inpatient medical hospitalizations

- Improved school performance as evidenced by:
  - an improvement in grades
  - a decrease in truancy or dropout

- Improved family functioning as evidenced by:
  - fewer days of conflict with family members
  - decreased runaway episodes

- Improved social functioning as evidenced by:

- less time spent with substance-using and/or delinquent peers
- increased friendships with non-substance using peers

- Improved psychological functioning as evidenced by:
  - fewer days of self-reported mood disorders
  - fewer admissions for psychiatric treatment, either inpatient or outpatient

These standards were evaluated through repeated administrations (6, 12, and 18 months) of a standardized assessment, the Adolescent Drug Abuse Diagnoses interview, and review of treatment and criminal records at each follow-up point.

It should be noted that youth in the comparison group might have also received substance abuse treatment services. The duration and intensity of services received, however, would not be expected to be as great as the services received by youth in CDDA. However, the comparison group should not be thought of as a "no treatment" group.

Legislation associated with CDDA requires that:

> *"…the department shall prioritize expenditures for treatment provided under RCW 13.40.165. The department shall provide funds for inpatient and outpatient treatment providers that are the most successful, using the standards developed by the University of Washington under section 27, chapter 338, Laws of 1997. The department may consider variations between the nature of the programs provided and clients served, but must provide funds first for those that demonstrate the greatest success in treatment within categories of treatment and the nature of persons receiving treatment."*

The ability of the outcome evaluation to document statistically that one treatment provider is more effective than another is limited for several reasons. There are four treatment modalities utilized in CDDA, each of which has numerous providers: (1) detention-based outpatient; (2) inpatient; (3) intensive outpatient; and (4) standard outpatient. The number of juveniles treated by each provider is, therefore, relatively small. There is also wide variation in the services being provided within each treatment modality (e.g., one inpatient program provides family education, another provides family meetings, another family therapy).

These factors make it impossible to make statistically meaningful comparisons of individual treatment provider outcomes. The outcome evaluation, however, is able to describe the aggregate outcomes of juveniles treated across the various treatment modalities and indicate which configuration of services relates to the most positive outcomes for locally sanctioned and committable juveniles based on measurement of the effectiveness standards.

This final report presents data collected from the baseline, 6-, 12- and 18-month assessments for committable and locally sanctioned youth. Follow-up rates for all interviews exceeded 85 percent (6-month: 98 percent, 12-month: 87 percent, and 18-month 86 percent).

Outcome Evaluation

A. Recruitment

As mentioned earlier, recruitment of youth for the CDDA Outcome Evaluation was conducted in eight counties between January 1999 and June 2001. A total of 403 youth were recruited into the study. Fifty-three of these youth were placed in Drug Court. Outcomes for youth in Drug Court will be discussed separately in a later section of this report. Table 1 below provides information on the number of youth, excluding those in Drug Court, recruited from each of the eight participating counties.

Table 1

Youth Recruited By County

	Committable			Locally Sanctioned		
	CDDA	Non-CDDA	Total	CDDA	Non-CDDA	Total
Benton/Franklin	1	2	3	3	2	5
Clark	7	9	16	11	0	11
King	2	4	6	13	10	23
Kitsap	4	0	4	10	7	17
Pierce	9	4	13	25	15	40
Snohomish	2	7	9	58	33	91
Spokane	3	13	16	5	58	63
Yakima	5	4	9	8	16	24
Total	33	43	76	133	141	274

Youth that were legally eligible for CDDA were required to complete a substance use assessment by a certified chemical dependency counselor (CDC) to determine their clinical eligibility for CDDA. If results of the assessment battery indicated that the youth was either a substance abuser or chemically dependent, the CDC recruited the youth for the CDDA outcome evaluation. Therefore, at the time of recruitment it was not known if the youth would actually enter CDDA, only that the youth was legally and clinically eligible for CDDA. The final decision to place a youth in CDDA occurred in a hearing scheduled approximately two weeks after the clinical assessment was conducted.

1. Baseline Differences Between Committable and Locally Sanctioned Youth

CDDA was designed to provide committable chemically dependent youth with supervised substance abuse treatment services as an alternative to JRA confinement. Committable youth are defined as those youth eligible for 15-36 weeks of confinement in a JRA facility. The majority of youth being evaluated and entering

CDDA have, however, been "locally sanctioned" youth. Locally sanctioned youth are youth eligible for 0-30 days in detention and up to 12 months of community supervision, but do not face the possibility of commitment to a JRA facility. Committable youth generally had more severe criminal and substance use histories and more problems in several other life domains (e.g., school, family) than locally sanctioned youth at the time of the baseline evaluation.

Table 2

Baseline Differences on Criminal Variables for 81 Committable and 322 Locally Sanctioned Youth

Variable	Committable	Locally Sanctioned
Lifetime Number of Times Picked Up By Police	12.7	8.2**
Lifetime Number of Arrests	8.0	5.7
Lifetime Number of Parole/Probation Violations	3.7	2.2**
Percent Having Spent a Month or More Incarcerated	51.9	21.4***
Number of Times Detained in Last 3 Months	2.4	1.5**
Number of Days of Illegal Activity in Past Month	9.2	7.7

**p<.01, ***p<.001

Committable youth had significantly more prior convictions compared to locally sanctioned youth (6.2 versus 4.8), and as seen in Table 2, were significantly worse on most other baseline measures of criminal history. Committable youth began using drugs earlier than locally sanctioned youth and were more likely to be diagnosed as chemically dependent (Table 3 on page 12). Committable youth reported using alcohol, marijuana, and tobacco for a longer duration than locally sanctioned youth as well as using more different kinds of drugs during the previous six months than locally sanctioned youth. Committable youth also reported receiving more previous inpatient or outpatient substance abuse treatments than locally sanctioned youth.

Committable youth also evidenced greater problems in school and in utilizing free time constructively compared to locally sanctioned youth. At baseline, significantly fewer committable youth were enrolled in school and they also reported significantly more expulsions from school than locally sanctioned youth. Significantly more committable youth reported spending "a lot of time" involved with gangs (15 percent versus 5 percent), more hours "hanging out" (4.9 versus 4.0), and having more friends that had been in trouble with the police (2.4 versus 1.7).

Table 3		
Baseline Comparison of Substance Use Variables for 81 Committable and 322 Locally Sanctioned Youth		
Variable	Committable	Locally Sanctioned
% Chemically Dependent	93.8	80.0*
Age Alcohol First Used	12.1	12.5
Age Any Drug First Used	11.8	12.4*
Age Tobacco First Used	11.7	12.2
# of Drugs Used in Previous Month	2.0	1.7
Months of Regular Alcohol Use	32.8	28.7
Months of Regular Marijuana Use	44.3	34.0***
Months of Regular Tobacco Use	52.4	34.0**
# Previous Outpatient Treatments	0.9	0.5
# Previous Inpatient Treatments	0.5	0.3*
		*p<.05, **p<.01, ***p<.001

There were also indications that committable youth had more psychological problems than locally sanctioned youth at baseline. More committable youth reported serious thoughts of suicide in the previous month (12 percent versus 4 percent) and worried that "something was wrong with their mind" (27 percent versus 17 percent) than locally sanctioned youth.

Committable and locally sanctioned youth in the study are predominately users of marijuana (89 percent), alcohol (80 percent), and tobacco (73 percent). Use of amphetamines was reported by 28 percent of the sample, and 24 percent reported use of hallucinogens. Use of other types of drugs (e.g., cocaine, inhalants) was reported by less than 10 percent of youth in the sample at baseline. Initial use of amphetamines, cocaine, and hallucinogens was less than four days a month. For all youth, use of these drugs decreased to less than 1 day a month over the 18-month period. Since relatively few youth were using these substances, and levels of use decreased over time for all youth, outcome analyses regarding substance use will focus on marijuana and alcohol use for both committable and locally sanctioned youth.

Because committable and locally sanctioned youth demonstrated significant and important initial differences on several variables related to criminal histories and substance use, the two groups of youth are not combined for data analyses. Study outcomes are presented separately for committable and locally sanctioned youth.

B. Committable Youth — Assessment Results

The number of committable youth recruited into the study was relatively small (N=81) compared to the number of locally sanctioned youth (N=322). The relative proportions of committable and locally sanctioned youth recruited into the outcome evaluation are, however, reflective of the statewide referrals to CDDA for committable and locally sanctioned youth (See Appendix 4).

Of the 81 committable youth in the study, 43 were placed on standard probation services (SPS), 33 were placed on CDDA, and 5 entered a Drug Court. The number of committable youth in Drug Court does not allow for meaningful statistical comparisons so youth in Drug Court have been excluded from the following analyses.

Of the 33 youth placed on CDDA, 36 percent (N=12) graduated and 64 percent (N=21) were n*on-completers* from the program. In the following sections of this report youth that successfully completed CDDA are referred to as the "*completers*" group. Youth that were revoked from CDDA and therefore failed to complete the program are referred to as the "n*on-completers*" group. Youth that were never placed in CDDA are referred to as the standard probation/parole services (*SPS*) group. This group of youth is used as a comparison group to determine if CDDA had a greater impact on criminal behavior, substance use, and functioning in other areas than the services typically provided to youth involved in the juvenile justice system with substance use problems.

Analysis of JUVIS records revealed no significant difference in the number of prior convictions between committable youth placed on CDDA and youth receiving SPS (6.5 versus 6.1). Nor was there a significant difference found at baseline in the number of prior convictions between CDDA *completers, non-completers,* or *SPS* youth.

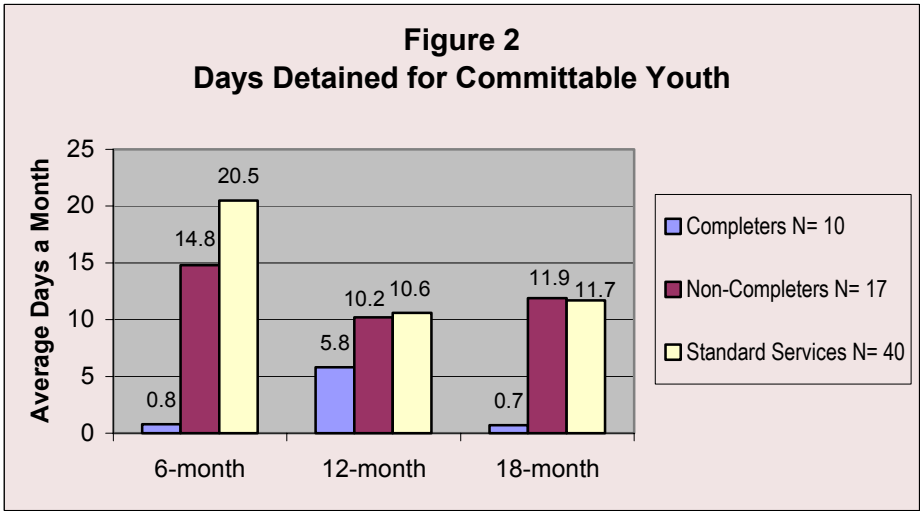
1. Criminal Behavior

Over the 18-month study period, completing CDDA was associated with significant reductions in criminal behavior. JUVIS records revealed that over the 18-month study, CDDA *completers* incurred half the number of convictions (0.4) that CDDA *non-completers* (0.8 convictions) and *SPS* youth (1.0) incurred. Significantly fewer CDDA *completers* than *non-completers* or *SPS* youth were detained at any time during the 18-month study period (40 percent, 76 percent, and 77 percent respectively). At the 18-month follow up fewer CDDA *completers* (30 percent) than *non-completers* (53 percent) or SPS youth (65 percent) were under legal supervision. Moreover, as shown in Figure 2 on page 14, CDDA *completers* were detained for fewer days than *non-completers* or *SPS* youth during the six months preceding each of the follow ups.

2. Substance Use

Regarding the "Effectiveness Standards" for substance use, no significant difference between CDDA *completers*, CDDA *non-completers*, and *SPS* youth was found in the number of emergency room visits, inpatient medical hospitalizations, or re-

admissions to inpatient or outpatient substance abuse treatment over the 18-month study period.



Over the 18-month study period, use of marijuana, alcohol and other drugs decreased significantly for all youth. The average days of marijuana use decreased from approximately 18 days per month at baseline to less than 5 days per month at the 18-month assessment. There were no significant differences between CDDA *completers*, *non-completers*, or *SPS* youth in the number of different drugs used or in the average monthly use of marijuana, alcohol, or any other substance at the 18-month assessment.

3. School Performance

Completing CDDA was associated with a greater likelihood of being enrolled in school or working. Although the percentage of youth earning average or above average grades did not differ significantly between the three groups at the 18-month follow up, a higher percentage of CDDA *completers* (80 percent) were enrolled in school compared to *non-completers* (47 percent) or *SPS* youth (70 percent).

Additionally, *completers* were more likely to be working full-time than *non*-c *completers* or *SPS* youth at the 18-month assessment (60 percent, 41 percent, and 24 percent respectively), and to have earned significantly more legal income ($1,006, $385, and $213 monthly, respectively) during the previous month. It is noteworthy that although the percentage of youth having earned a high school diploma or GED was not significantly different between the three groups, at the 18-month follow up the only two committable youth enrolled in community college were both CDDA *completers*.

4. Family Functioning

In general, running away from home occurred infrequently in this sample; 95 percent of youth reported no episodes during the 18-month period. No significant differences in the number of times that a youth ran away were found between CDDA *completers*, *non-completers*, or *SPS* youth. Although there were no significant differences revealed between the three groups in the percentage of youth reporting "fights or arguments" with family members over the study period, there were other indicators that CDDA positively impacted family relationships. None of the *completers* reported stealing from their families during the previous 6 months at the 18-month interview compared to 25 percent of *non-completers* and 5 percent of *SPS* youth. Moreover, approximately 20 percent of youth in CDDA (*completers* and *non-completers*) reported that their parents understood them compared to only 6 percent of *SPS* youth.

5. Social Functioning

Completing CDDA appeared related to establishing more positive peer relationships in committable youth. Fewer *completers* than *non-completers* or *SPS* youth reported spending "a lot of time" with drug-using peers (5 percent, 21 percent, and 74 percent respectively) at the 18-month follow up. While 100 percent of CDDA *completers* and *non-completers* reported no involvement with gangs, 13 percent of *SPS* youth reported recent gang involvement at the 18-month assessment.

6. Psychological Functioning

The average number of inpatient and outpatient admissions for all groups was less than one over the 18-month study, and there were no significant differences between CDDA *completers*, *non-completers* or *SPS* youth in the number of inpatient or outpatient treatments for psychological problems. No significant differences between the three groups were found in the number of days of psychological problems (i.e., depression, anxiety, impulse control) reported in the previous month at the 6-, 12- or the 18-month assessment. However, at the 18-month assessment results suggest that CDDA *completers* had fewer emotional problems. None of the *completers* reported experiencing significant anxiety compared to 12 percent of *non-completers* and 15 percent of *SPS* youth. Additionally, none of the *completers* reported difficulty controlling their temper, while 12 percent of *non-completers* and 27 percent of *SPS* youth reported trouble controlling their temper during the previous month.

7. Treatment Activities

Table 4 (on page 16) provides information from DASA's Treatment and Assessment Report Generation Tool (TARGET) database on the average number of days *completers*, *non-completers*, and *SPS* youth spent in each treatment modality over the 18-month study period.

Over the 18 months, youth in CDDA (*completers* and *non-completers*) spent significantly more time in inpatient and intensive and standard outpatient treatment compared to *SPS* youth. CDDA *completers* spent significantly more time than *non-*

completers in standard outpatient treatment, but not more time in inpatient or intensive outpatient treatment.

Information on the average number of services received by each group while in treatment is also presented in Table 4 below. While in treatment, CDDA *completers* received significantly more of all types of treatment services (e.g., individual counseling, urine drug screens) than *non-completers* or *SPS* youth.

Table 4

Average Number of Days of Treatment For the 18-Month Study Period—Committable Youth

	CDDA Completers	CDDA Non-Completers	Standard Services	F-Value
Treatment Modality	N=12	N=21	N=43	
Inpatient	18.2	23.21	1.6	9.7***
Intensive Outpatient	39.4	32.2	16.9	0.4
Standard Outpatient	232.9	74.0	24.9	26.3***
Recovery House	0	1.6	0	1.3
Group Care Enhancement	0	0	21.9	1.5
Treatment Activities				
Conjoint with Family	2.5	0.1	0.2	17.1***
Family Without Client	0.6	0.1	0	9.5***
Individual	12.6	3.1	2.1	18.9***
Group	43.7	18.9	8.1	10.5***
Case Management	4.9	2.0	1.0	3.2*
Urine Drug Screens	10.8	3.1	0.2	8.2***
				*p<.05, ***p<.001

Appendix 3 provides a description of treatment requirements for each modality of treatment. In all forms of outpatient treatment, youth were expected to receive weekly one hour of individual counseling, one hour of group counseling, one hour of case management, one urine drug screen, and family services (i.e., family therapy, parent training/support). Considering that TARGET records show that on average, CDDA *completers* spent 33 weeks in standard outpatient treatment, *completers* would have been expected to received approximately 33 hours of individual counseling, case management, 33 urine drug screens, and significantly more family services according to CDDA guidelines.

8. Summary—CDDA for Committable Youth

CDDA was designed to provide a continuum of substance abuse treatment services as an alternative to incarceration for committable youth with substance use problems. Completing CDDA for committable youth was associated with significant reductions in the likelihood of being re-convicted and incarcerated. CDDA *completers* were more likely to be involved in school or employed than CDDA *non-completers*, or youth receiving *SPS*. CDDA also appeared to positively impact youths' social and familial relationships, and psychological functioning. There was no indication, however, that CDDA had significant long-term impacts on youths' substance use.

C. Locally Sanctioned Youth

Of the 322 locally sanctioned youth in this study, 133 were placed in CDDA, 48 were placed in Drug Court and 141 were placed on *SPS*. Although the CDDA and Drug Court programs have many similarities, they differ in important ways that will be discussed later. Therefore, the CDDA and Drug Court 18-month outcome results are presented separately for locally sanctioned youth.

The group of 141 locally sanctioned youth on *SPS* will be used as a comparison group in the outcome analyses of CDDA for locally sanctioned youth. Those youth that successfully completed the CDDA program are referred to as the "*completers*" group. Youth that were revoked from CDDA and therefore failed to complete CDDA are referred to as the "*non-completers*" group.

1. CDDA Assessment Results

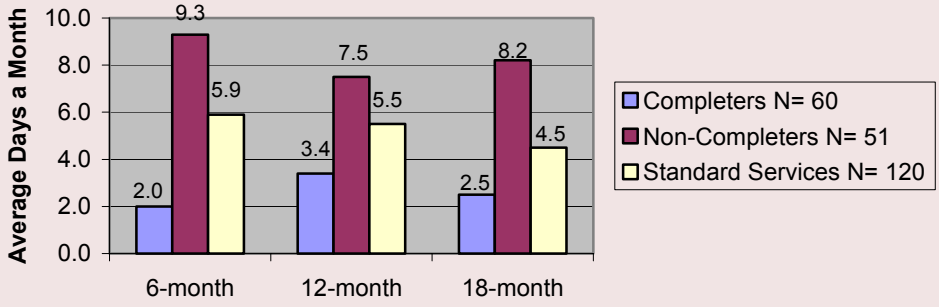
Of the 133 locally sanctioned youth placed in CDDA, 50 percent (N=67) completed the program (*completers* group). The only significant differences found at baseline between the 67 locally sanctioned CDDA *completers*, 66 CDDA *non-completers*, and 141 *SPS* at baseline were related to substance use. CDDA *completers* reported a shorter duration of regular drinking (23 months) than *non-completers* (33 months) or *SPS* youth (29 months). However, at baseline more of the CDDA *non-completers* reported previously trying to curtail their substance use compared to *completers* or *SPS* youth (68 percent, 53 percent, and 43 percent respectively).

a. Criminal Behavior

Analysis of JUVIS records revealed no significant baseline differences in the number of prior lifetime convictions between locally sanctioned CDDA *completers*, *non-completers* or *SPS* youth. As found with committable youth, there were several indications that for locally sanctioned youth completing CDDA reduced youths' illegal behavior. Over the 18-month study CDDA *completers* had significantly fewer convictions (0.8) than CDDA *non-completers* (1.8) or *SPS* youth (1.0). During the study period, 40 percent of *completers* were detained at some time compared to 62 percent of *non-completers* and 52 percent of *SPS* youth.

Additionally, Figure 3 below illustrates that CDDA *completers* spent significantly less time detained at each assessment point than *non-completers* or *SPS* youth. At the 18-month follow up, significantly fewer CDDA *completers* reported an illegal income during the previous 6 months of more than $500 compared to CDDA *non-completers* or *SPS* youth (15 percent, 31 percent, and 26 percent respectively).

Figure 3
Days Detained for Locally Sanctioned Youth
CDDA Program



b. Substance Use

No significant differences for locally sanctioned youth between CDDA *completers*, CDDA *non-completers*, or *SPS* youth were found in the number of emergency room visits, inpatient medical hospitalizations, and inpatient or outpatient substance abuse treatments. Over the 18-month study period, use of marijuana decreased significantly for all youth from approximately 16 days per month to 8 days per month. Alcohol use remained stable over time at approximately five days a month for youth in all groups. There were no significant differences in marijuana or alcohol use over time between the CDDA *completers*, *non-completers* or *SPS* youth. Nor were significant differences found between the three groups in the number of different drugs used over time.

c. Other Measures

No significant differences were found between locally sanctioned CDDA *completers*, CDDA *non-completers* or *SPS* youth over the 18-month study period on any measure assessing youths' general functioning in school, employment involvement, family or social relationships, or overall psychological well-being.

d. Treatment Activities

As shown in Table 5 below, generally CDDA *completers* spent a longer time in treatment and received more services than *non-completers* or *SPS* youth during the 18-month study period. With the exception of group care, recovery house, and individual counseling, differences in the amount of time spent in the treatment modalities and in the amounts of services received while in treatment were all significant between the three groups.

Table 5 Treatment Records For An 18-Month Study Period Locally Sanctioned Youth—CDDA Program				
	CDDA Completers	**CDDA Non-Completers**	**Standard Services**	**F-Value**
Treatment Modality	N=67	N=66	N=141	
Inpatient	27.9	17.3	7.4	10.7***
Intensive Outpatient	98.7	52.3	17.0	20.5***
Standard Outpatient	110.8	106.3	34.0	14.1***
Recovery House	5.6	1.4	1.9	1.8
Group Care Enhancement	5.7	5.9	0	0.8
Detoxification	4.3	6.3	0.5	5.6**
Treatment Activities				
Conjoint with Family	1.2	0.6	0.1	5.5**
Family Without Client	0.4	0.4	0	5.8**
Individual	7.4	4.2	2.1	16.4
Group	38.3	23.3	6.7	33.4***
Case Management	4.9	1.9	1.2	7.6***
Urine Drug Screens	4.7	2.5	0.7	16.1***
				**p<.01, ***p<.001

As mentioned earlier, youth in CDDA are expected to receive one hour of individual counseling, one hour of group counseling, one hour of case management, one urine drug screen, and some type of family services (i.e., family therapy, parent training/support) each week. Considering that locally sanctioned CDDA *completers* spent an average of 14 weeks in intensive outpatient treatment, it would be expected that they would have received at least 14 hours of individual counseling, family services, case management, and urine drug screens. As seen in Table 5, however, *completers* received substantially less than 14 hours of these services while in treatment.

Because youth in the standard services group also received some treatment services, data was re-analyzed dividing youth into those receiving any substance treatment (N=73) and those that received no substance abuse treatment (N=172) over the 18-month study period. No significant differences in substance use were found when this analysis was done. This suggests that the lack of significant group differences in substance use is not related to the fact that many youth in the SPS groups received some treatment services. The lack of family services, individual counseling, case management and urine drug screens given to youth in CDDA may, in part, explain the lack of findings for locally sanctioned youth.

e. Summary—CDDA for Locally Sanctioned Youth

As was the case for committable youth, completing the CDDA program for locally sanctioned youth reduced the likelihood of convictions and incarceration, and reduced the duration of any incurred incarceration but did not significantly reduce substance use compared to standard services. CDDA's impact on other areas of functioning for locally sanctioned youth was less evident than for committable youth. Completing CDDA was not related to increased involvement in school or work, improved family or social relationships, or overall psychological well-being in locally sanctioned youth as it was with committable youth.

2. Drug Court Assessment Results

Drug Court, like CDDA, is a 12-month long program for juvenile offenders with substance use problems that integrates legal supervision and enhanced substance abuse treatment. Drug Court and CDDA both are designed to provide a comprehensive continuum of substance abuse treatment services based on individuals' needs. Similarly to youth in CDDA, youth in Drug Court are expected to receive increased amounts of treatment services (e.g., weekly individual counseling, family services, weekly urine drug screens). However, several noteworthy differences exist between the Drug Court and CDDA programs.

Unlike CDDA, Drug Court was designed primarily for locally sanctioned youth and therefore the incentives for program participation differ. The ability to retain one's driver's license while actively involved in Drug Court and dismissal of the index charge when the program is successfully completed are the primary incentives for youths' participation in Drug Court. The primary incentive for CDDA participation is the avoidance of long-term incarceration; most youth in Drug Court do not face long-term incarceration. Another difference between Drug Court and CDDA is that youth in Drug Court are required, for several months, to attend weekly meetings with a "Drug Court Team." The Juvenile Court Judge is primary member of this Team and reviews the youths' progress in treatment and other areas of functioning (e.g., school, work) on an individual basis each week. Youth in CDDA have no regular meetings with the Judge.

Youth in Drug Court were significantly different from youth in CDDA, and those on standard services (SPS youth), in several important ways that are illustrated in Table 6 below. Generally, youth in Drug Court were assessed as those with the most stable homes and the least severe problems in school at baseline. Youth in Drug Court did not report more problems associated with their substance use than youth in the other groups, but where found to have had significantly fewer prior convictions in JUVIS records than youth in CDDA.

TABLE 6				
Comparisons of 133 CDDA, 48 Drug Court and 141 Comparison Youth				
Variable	**CDDA**	**Drug Court**	**Standard Services**	**X^2 or F-Value**
Age	15.8	15.6	15.7	1.8
% Caucasian	75.3	83.3	75.7	3.5
% African American	8.6	5.6	7.3	0.5
% Hispanic	8.4	0	10.7	7.0*
% Native American	5.6	5.6	4.0	0.5
% Asian	1.9	5.6	1.1	0.7
% Living With Both Parents	19.7	33.3	13.3	10.9**
% Ever in Foster Care	18.7	8.9	26.5	7.9*
# Times Ran Away	3.3	2.0	4.8	3.2*
Current Grade in School	9.3	10.2	9.6	7.1***
% Lying to Parents in Last Month	65.2	43.3	52.4	9.1**
% Reporting that Drug Use Caused Trouble with Parents in Last Month	57.9	38.9	46.5	6.3*
% Feeling That "Something is Wrong with My Mind"	17.4	6.7	21.7	6.7*
% Reporting "Trouble Controlling Temper" Last Month	34.1	28.3	37.8	1.7
Number of Lifetime Convictions	4.9	2.9	4.9	7.4***
% Previously Spending a Month or More in Jail	23.5	3.3	27.3	53.5***
% Chemically Dependent	83.2	78.9	77.5	4.8
				*p<.05, **p<.01, ***p<.001

Although youth in Drug Court did not have more severe substance use problems than youth in the other two groups at baseline, over the 18-month study period they spent significantly more time in standard outpatient treatment than youth in CDDA. Table 7 below shows that Drug Court youth also received significantly more individual counseling, case management, and urine drug screens while in treatment compared to youth in CDDA. Drug Court youth spent significantly more time in most modalities of treatment and received significantly more of all types of services while in treatment compared to *SPS* youth.

Table 7

Treatment Records For 322 Locally Sanctioned Youth Over An 18-Month Study Period

	CDDA	Drug Court	Standard Services	F-Value
Treatment Modality	N= 133	N =48	N=141	
Inpatient	22.7	16.7	7.4	3.0***
Intensive Outpatient	73.0	87.2	16.9	17.4***
Standard Outpatient	108.8	187.8	34.2	34.9**
Recovery House	3.4	7.0	1.9	2.0
Group Care Enhancement	3.3	0.7	5.9	0.5
Detoxification	1.5	2.1	0	9.8***
Treatment Activities				
Conjoint with Family	0.9	1.8	0	8.9***
Family Without Client	0.4	0.9	0.1	4.8**
Individual	6.0	11.3	2.1	37.6***
Group	30.2	37.9	6.7	37.8***
Case Management	4.0	19.2	1.6	33.3***
Urine Drug Screens	3.7	10.8	0.7	43.1***
				**p<.01, ***p<.001

Since the three groups are unequal in terms of their legal history, which could influence the likelihood of future illegal activity and substance use, it is inappropriate to compare the criminal and substance use outcomes of youth in Drug Court to outcomes of youth in CDDA.

It would also be inappropriate to compare the outcomes of Drug Court youth to the sample of 141 *SPS* youth since the *SPS* youth had a more extensive criminal history. Therefore, based on criminal histories, a group of 93 youth were selected from the sample of *SPS* youth whose criminal histories were more comparable to those of youth in Drug Court. This group of 93 locally sanctioned youth receiving standard probation services will be referred to as the "*comparison*" group in the following sections. The average number of prior convictions for the *comparison* group did not significantly differ from that of the Drug Court group (2.9 versus 2.7 respectively). Nor did the groups differ in the severity of initial substance use problems as measured by the percent of youth diagnosed as chemically dependent (78.9 percent versus 74.7 percent).

The youth in Drug Court were recruited from three counties: King (N=21), Kitsap (N=14), or Snohomish County (N=18). Five of the youth were committable and therefore were excluded from the following analyses of locally sanctioned youth. Of

the 48 locally sanctioned youth placed in Drug Court, 60 percent completed (N=29) the program and 40 percent did not complete the program (*non-completers* group, N=19).

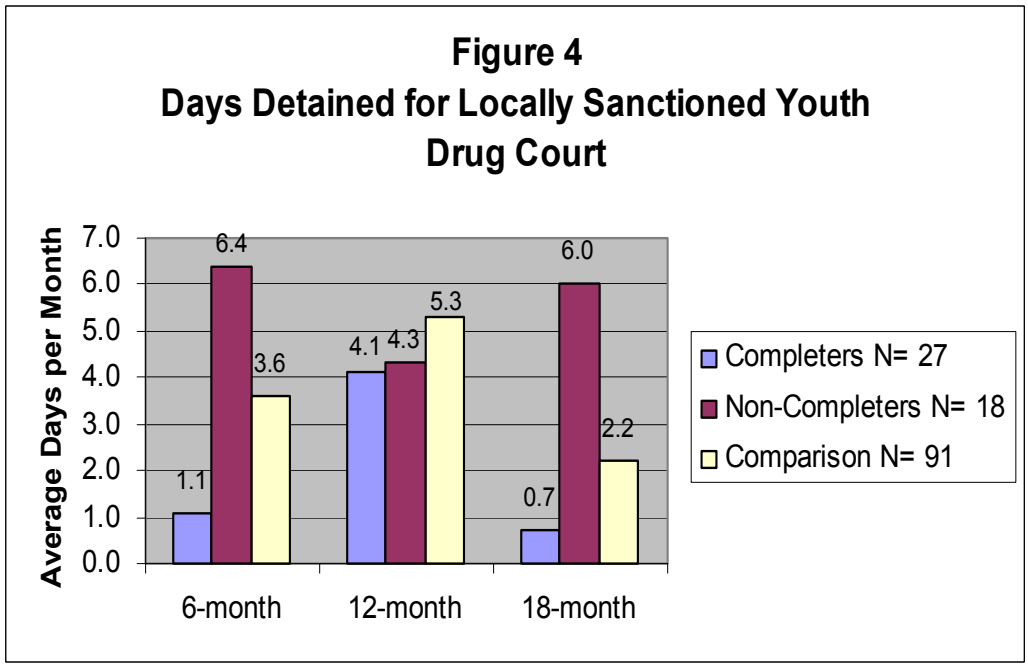
Several baseline differences were found between Drug Court *completers*, Drug Court *non-completers* and *comparison* youth suggesting that youth completing Drug Court had more stable living situations and less involvement with alcohol. Analysis of JUVIS records revealed that Drug Court *completers* had significantly fewer prior lifetime convictions (2.0) than *non-completers* (3.9) or *comparison* youth (2.7). Drug Court *completers* were more likely than *non-completers* or *comparison* youth to be living with both parents and never to have been homeless. Drug Court *completers* were less likely to have been recently fighting or arguing with parents, to previously have spent more than one month incarcerated, or to have been drunk during the previous month than youth in the other two groups. Compared to *completers* and *comparison* youth, Drug Court *non-completers* had significantly more past outpatient treatments for "emotional problems" (0.7, 0.5, 1.3 respectively).

a. Criminal Behavior

There were significant group differences in the number of convictions incurred over the study period. Drug Court *completers* incurred on average 0.1 convictions compared to 1.7 for *non-completers* and 0.9 for *comparison* youth. Drug Court also appears to be effective in reducing the percent of locally sanctioned youth incarcerated and the length of incarceration time. Overall, 40 percent of *completers* were incarcerated during the 18-month study period compared to 61 percent of *non-completers* and 53 percent of *comparison* youth. As shown in Figure 4 on page 24, Drug Court *completers* spent significantly less time detained in the 6 months preceding the 6-month and 18-month assessment point than *non-completers* or *comparison* youth.

b. Substance Use

No significant differences were found between groups in the number of emergency room visits or in the number of inpatient hospitalizations or substance abuse treatment admissions. There were no significant differences between the three groups of locally sanctioned youth in the number of different types of drugs used at any point in time, or in the average use of alcohol and marijuana. Use of marijuana in the sample decreased from an average of 16 days per month at baseline to an average of 8 days per month at the 18-month assessment. Use of alcohol remained relatively unchanged. Youth in the study averaged 6 days per month of alcohol use at baseline and 5 days per month of alcohol use at the 18-month assessment.



c. Other Measures

No statistically significant differences between locally sanctioned Drug Court *completers*, Drug Court *non-completers* or *comparison* youth were found on any variable assessing involvement in school and or employment, family relationships, or social and psychological functioning at the 6-, 12-, or 18-month assessment.

d. Treatment Activities

As found for youth in CDDA, locally sanctioned youth in Drug Court (*completers* and *non-completers*) spent significantly more time in all forms of treatment except group care and recovery houses versus *comparison* youth (Table 8, page 25). Drug Court *completers* spent significantly more time in intensive outpatient treatment than *non-completers*, but not significantly more time in any other treatment modality.

Table 8 Treatment Records For An 18-Month Study Period Locally Sanctioned Youth-Drug Court Program				
	Drug Court Completers	**Drug Court Non-Completers**	**Comparison**	**F-Value**
Treatment Modality	N=29	N=19	N=93	
Inpatient	18.1	14.4	7.6	2.0
Intensive Outpatient	115.2	48.3	18.9	17.4***
Standard Outpatient	190.0	174.0	35.2	34.9***
Recovery House	7.8	6.4	2.0	2.0
Group Care Enhancement	0	1.7	3.7	0.2
Detoxification	2.6	1.7	0	9.8***
Treatment Activities				
Conjoint with Family	1.9	1.6	0.2	9.7***
Family Without Client	0.3	1.8	0	4.4**
Individual	13.7	8.9	2.1	25.3***
Group	40.9	32.5	7.3	33.1***
Case Management	20.2	19.6	1.8	23.9***
Urine Drug Screens	14.2	7.2	0.7	32.5***
				**p<.01, ***p<.001

While in treatment, *completers* and *non-completers* were involved in significantly more treatment activities of all types than *comparison* youth. Completers were involved in more individual and family counseling and received more urine drug screens in treatment than Drug Court *non-completers*. However, the amount of individual counseling, family services, case management, and urine drug screens provided to youth in Drug Court was lower than anticipated given the amount of time spent in the program.

No significant groups differences in substance abuse were revealed when comparing youth that did (N=72) and did not (N=52) receive any treatment services, except that youth that received treatment reported significantly more days of drinking at the 18-month assessment than those receiving no treatment (6 days versus 3 days per month respectively).

e. Summary—Drug Court for Locally Sanctioned Youth

Drug Court was successful in providing youth with increased substance abuse treatment services. Locally sanctioned youth completing Drug Court had fewer convictions and reduced the rate and duration of incarceration during the study period compared to youth not involved in Drug Court. There was no evidence

that Drug Court participation significantly reduced the use of marijuana, alcohol, or any other substance over the 18-month study period. Nor were there significant group differences on measures assessing functioning in school, with family, peers, or psychological well-being.

D. Discussion

The 12-month CDDA program was designed to provide committable youth with substance use problems a continuum of substance abuse treatment services and increased monitoring of behavior as an alternative to long-term incarceration. Youth successfully completing CDDA are expected to demonstrate significantly lower levels of illegal activity and substance use, and improved overall functioning in other areas (e.g., school, family relationships) compared to youth that did not receive CDDA services.

Based on a review of the literature, it was initially recommended that all CDDA treatment programs, regardless of modality, should include the following elements. In order to be effective, treatment should:

- Be delivered in the least restrictive setting, while considering issues of community safety.
- Be comprehensive and address the problems identified by the evaluation process (e.g., psychiatric disturbance, sexual abuse).
- Involve the family, or a family substitute, in all aspects of treatment planning, discharge, and continuing care recommendations.
- Include family therapy and cognitive-behavioral therapy.
- Include general life skills, decision-making, and coping skills education and training.
- Emphasize relapse prevention.
- Be a continuum of care; meaning upon discharge from a program additional services are provided, in decreasing frequency, so that each adolescent will have services available for at least 12 months.

While CDDA appears to have been successful in delivering treatment in the least restrictive setting as primarily outpatient services were utilized, it does not appear that families have been involved in all aspects of treatment. Research on treatment for adolescent substance abuse problems finds that positive treatment outcomes are most consistently related to programs involving the family. Studies find that generally having a supportive family that is involved in youths' treatment is associated with better treatment outcomes (Dembo et al., 2000; Friedman, Terras, and Kreisher, 1995; Hawkins, Lishner, Jenson and Catalano, 1995;

Stice, Barrera and Chassin, 1993; Huey and Henggeler, 2001; Orlando, Chan and Morral, 2003).

Urine drug screens and case management were to be employed in CDDA as part of relapse prevention. Frequent utilization of drug screens and case management meetings were expected to increase the probability that any substance use would quickly be detected. Treatment programs could then intervene to decrease the likelihood of continued substance use. At least during the initial phases of outpatient treatment, it was recommended that youth in CDDA receive weekly case management and urine drug screens. However, case management and urine drug screens were not administered as frequently as planned.

It is unclear from existing TARGET records whether cognitive behavioral therapy, coping skills, and other individualized trainings (e.g., anger management) were provided to CDDA youth. Provision of such services should increase the effectiveness of CDDA. Generally, it appears that CDDA increased the number of substance abuse services to youth, but did not modify the types of services provided. Substance abuse treatment programs that do not include family involvement and the treatment elements listed above are unlikely to result in long-term changes in substance use.

Although designed for committable youth, the majority of youth placed in CDDA to date have been locally sanctioned. Committable youth typically have more extensive criminal and substance use histories compared to locally sanctioned youth. Therefore the impact of CDDA participation on youths' behavior was considered separately for committable and locally sanctioned youth. For committable youth, completing CDDA was associated with significant decreases in involvement with the juvenile justice systems (i.e., fewer convictions and incarcerations), and increased involvement in school, employment, and more positive peer and family relationships. CDDA did not appear to significantly reduce levels of substance use. Completing CDDA for locally sanctioned youth was also associated with significant reductions in criminal behavior, but did not impact substance use or functioning in other areas.

The lack of findings regarding substance use for committable and locally sanctioned youth may be primarily related to the types and amounts of substance abuse treatment services received over the 18-month study period. Despite the fact that committable youth had the most severe substance use problems, as a group they spent the least amount of time in treatment and received the fewest services while in treatment compared to locally sanctioned youth. Committable and locally sanctioned youth in CDDA received substantially fewer individual, case management, urine drug screens, and family services than was expected based on CDDA guidelines.

While a deficiency in specific treatment services may be the primary reason for a lack of findings regarding substance use for CDDA youth, the initial severity of substance use problems and criminal history also needs to be considered. Substance use should not invariably lead to a diagnosis of substance abuse or dependence. Just as involvement in illegal behavior during adolescence does not necessarily foretell adult antisocial behavior. Research has demonstrated that there are adolescents who try minor delinquent behaviors,

such as shoplifting and drug use as part of normal rebelliousness during the maturational process. Among these "normal" adolescents, delinquent behavior typically peaks between 15-17, while drug involvement increases during the teen years and peaks in the early twenties (Hawkins, 1995; Moffitt, and Caspi, 2001).

A landmark longitudinal study found that adolescents who had experimented with drugs and alcohol in adolescence were actually psychologically better adjusted as young adults (less anxious, greater social skills, more flexible) than adolescents who had never tried drugs or alcohol, and better adjusted than adolescents who became heavy users of alcohol and drugs (Shedler and Block, 1990). There is another group of adolescents that becomes seriously involved in substance use and criminal activity during its youth and continues that involvement into adulthood. It is likely that there are different etiologies involved in the development of "experimental substance use" and the more "life persistent substance use" (Moffitt, and Caspi, 2001).

Given the less extensive criminal and substance use histories of the locally sanctioned youth compared to that of committable youth, a greater percentage of locally sanctioned youth may be "experimental" substance users. Initially, locally sanctioned youth in this sample reported an average of 16 days per month of marijuana use and 6 days of alcohol use. Forty-six percent of all locally sanctioned youth reported smoking marijuana less than 9 days a month, compared to 26 percent of the committable youth. This level of use may not have been viewed as problematic by youth and may not have significantly interfered with their functioning in school, work, or family relationships. As a result, these youth may have felt little incentive to modify their substance use. Many of these youth will cease substance use as they mature and be unlikely to be chemically dependent as adults. It may be inappropriate to place these "experimental" types of users in CDDA, which was developed to treat youth with more severe substance use problems.

Provision of services and the degree of initial substance use severity may also explain why youth completing Drug Court also did not exhibit more significant differences compared to youth not in Drug Court. However, there are several study limitations that may also have influenced findings concerning Drug Court. The sample of Drug Court youth is relatively small in size thereby limiting the study's ability to reveal statistically significant group differences. A more important factor however, is that Drug Court youth in this study represent some of the earliest program participants. Drug Court participants were generally recruited during the programs' first year of implementation. Significant changes to Drug Court may have been made after review of the programs' first year of implementation. Therefore this study's findings may not be reflective of current Drug Court services and outcomes for current Drug Court participants. Therefore, study results for Drug Court should be viewed only as preliminary findings.

It is noteworthy that only about half of the youth entering CDDA or Drug Court successfully completed the program. The current research provides no information on the primary reasons why youth failed to complete CDDA and Drug Court. Given the promising findings regarding CDDA's ability to reduce criminal involvement and overall functioning, especially for committable youth, it is important that completion rates be increased.

Additional research focusing on identifying factors related to why youth fail in these programs and methods that could be employed to increase program retention is needed to maximize benefits from CDDA.

In summary, findings from this study indicate that completing CDDA reduces criminal involvement. Notwithstanding this success, CDDA has been unsuccessful in providing youth with a constellation of treatment services that research demonstrates are related to significant decreases in substance use and improvements in overall functioning. The failure of treatment services to include these elements may, in part, explain why significant differences in substance use were not evident between youth in CDDA and those not in CDDA.

RECOMMENDATIONS*

Although results indicate that CDDA is effective in reducing criminal involvement of committable and locally sanctioned youth, CDDA has not been implemented as designed with respect to treatment services. It is critical that youth in CDDA receive the elements of treatment that research has shown decreases substance use and improves overall functioning. Without ensuring that youth receive family services, weekly drug screens, case management as well as individual therapy using cognitive-behavioral techniques and life skills training, CDDA may continue to be ineffective in reducing substance use and impacting functioning in other areas.

- Therefore, it is recommended that JRA and DASA establish a method of monitoring treatment programs' adherence to CDDA treatment services guidelines. Funds for family therapy should be made available for youth in CDDA. The CDDA Advisory Committee, including key stakeholders from the juvenile courts and the treatment community, should be re-convened to address the above issues.

- It is also recommended that the eligibility requirements for CDDA be reconsidered. CDDA was designed for committable youth and CDDA's impact was strongest for committable youth. Treating youth that do not evidence substantial substance use problems may not be the optimal use of CDDA resources. CDDA resources may be better used to treat the more extensive criminal and substance use problems of committable youth than the less extensive problems of locally sanctioned youth.

- Additional research focusing on the services received and the outcomes of youth participating in CDDA programs that provide the recommended elements of treatment is needed. Additional studies of committable youth are especially needed as the number of committable youth in this study is relatively low. Future studies should also include a longer post-program completion follow up to determine if gains made in the CDDA program are maintained over time.

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Attachment 1

Department of Social and Health Services
Juvenile Rehabilitation Administration

Response to the

University of Washington's
Final Evaluation Report of the
Chemical Dependency Disposition Alternative (CDDA)

The Department of Social and Health Services' Juvenile Rehabilitation Administration (JRA) contracted with the University of Washington Alcohol and Drug Abuse Institute to complete its final evaluation study of the Chemical Dependency Disposition Alternative (CDDA) . The study was conducted in eight county juvenile courts for approximately 18 months and included 403 youth. The evaluation compared recidivism, substance abuse, school performance, and family relationships.

Based on the University of Washington's recommendations, JRA has developed an action plan to review the recommendations and improve the delivery of effective CDDA services. JRA Assistant Secretary Cheryl Stephani has asked the CDDA Advisory Workgroup to complete an assessment which will include:

- Review evidence-based drug and alcohol treatment interventions proven to attain positive outcomes and consider inclusion of them in CDDA;
- Identify specific populations most likely to benefit from CDDA services;
- Consider the inclusion of research-based family intervention in CDDA;
- Develop adherence measures for substance abuse treatment providers delivering CDDA treatment services; and
- Use information from the Washington State Institute for Public Policy (WSIPP) to incorporate quality control standards for research-based treatment services into CDDA.

JRA, through this action plan, will be addressing items as outlined in the December 2003 WSIPP report, ***Recommended Quality Control Standards: Washington State Research-Based Juvenile Offender Programs."**** It is anticipated that CDDA services will gain effectiveness as JRA, county juvenile courts, and the department's Division of Alcohol and Substance Abuse partner to refine drug and alcohol treatment for juvenile offenders.

Appendix 1

CDDA Treatment Model

Prescreen
Washington State Risk Assessment Tool
Or SASSI/PESQ

Substance Abuse Indicated by Screen

CDDA Assessment
ADAD/K-SADS

Youth is Chemically Dependent and Court-Ordered to CDDA
All youth receive 12 months of supervision and enter one of the following models of treatment

Detention-Based Treatment	Inpatient Treatment	Intensive Outpatient Treatment	Outpatient Treatment or Individual Outreach
30 Days	**30 – 90 Days**	**90 Days**	**9 – 12 Months**
• A minimum of 72 hours of direct treatment services within the 30 days. • Group, relapse, individual, and family therapy. Clinical consultation for mental health issues.	• Level I and Level II facilities. A minimum of 20 hours counseling services per week. • Group, individual, and family therapy. • Urinalysis Testing • Level II is available for youth with additional issues, such as mental illness. Facilities are locked or staff secure.	• 9 hours of group, and individual therapy per week. • Urinalysis testing • Family Therapy • Case Management	• 1-3 hours of group and/or individual therapy per week. • Urinalysis Testing • Family Therapy • Case Management
Intensive Outpatient 90 Days Outpatient 8 Months	Intensive Outpatient 90 Days Outpatient 7.5 Months	Outpatient 9 Months	

Appendix 2

Current Treatment Models by County

All treatment programs include a combination of increased supervision by juvenile courts, a case manager, a family services component, and a combination of the treatment modalities listed below.

Inpatient treatment services are available to all county courts.

Detention-Based Treatment:	Clallam, Clark, Columbia/Walla Walla, Kitsap, Kittitas (tied to Yakima), Okanogan, Pierce, Thurston, and Yakima
Intensive Outpatient Treatment:	Adams, Asotin/Garfield, Benton/Franklin, Chelan, Clallam, Columbia/Walla Walla, Cowlitz, Douglas, Ferry/Stevens/Pend Oreille, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Okanogan, Pacific/Wahkiakum, Pierce, Skagit, Snohomish, Spokane, Thurston, Whatcom, Whitman, and Yakima.
Community-Based Outpatient Treatment:	Benton/Franklin, Clallam, Clark, Ferry/ Stevens/Pend Oreille, Island, Lincoln, Snohomish, Pierce, and Yakima

Appendix 3

Description of Requirements for CDDA Treatment Modalities

Inpatient Treatment

- Level I and Level II provide a minimum of 20 hours of counseling services per week in accordance with WAC 440-22-410.
- Services shall include individual, group, and family services.
- Level II treatment is available for youth with issues in addition to chemical dependency such as mental health issues. The facilities contracted for CDDA are locked or staff secure.

Detention-Based Outpatient Treatment

- A minimum of 72 hours of direct treatment services within the 30 days.
- Treatment components would include: chemical dependency group counseling, education, family counseling and/or family issues group counseling, relapse prevention planning and counseling, individual counseling, case management, and continuing care planning.
- Clinical consultation to address mental health and other clinical complications.

Intensive Outpatient Treatment

- A minimum of 3 hours of group counseling a week.
- 1 hour of individual counseling a week.
- 1 hour of case management advocacy a week.
- Weekly urinalysis.
- Family services (family therapy and or parent training).

Outpatient Treatment

- 1 hour of support group a week.
- 1 hour of individual counseling a week.
- Family services (Family Therapy and/or Parent Training/Support).
- 1 hour of case management advocacy/week.
- Urinalysis (weekly).

Individualized Outreach

- 1-2 hour of individual counseling a week.
- Family services (Family Therapy and/or Parent Training/Support).
- 1 hour of case management advocacy/week.
- Urinalysis (weekly).

Appendix 4

CDDA Utilization Over Time for Committable And Locally Sanctioned Youth